ASSESSMENT

OF THE

USAID/RUSSIA

WOMEN AND INFANT HEALTH (WIN) PROJECT

EXECUTIVE SUMMARY

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December 2001

Submitted by:
LTG Associates, Inc.
TvT Associates, Inc.

Submitted to:
The United States Agency for International Development/Russia
Under USAID Contract No. HRN–C–00–00–00007–00

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Assessment of the USAID/Russia Women and Infant Health (WIN) Project was made possible through support provided by the United States Agency for International Development (USAID)/Russia under the terms of Contract Number HRN–C–00–00–00007–00, POPTECH Assignment Number 2001–032. The opinions expressed herein are those of the authors and do not necessarily reflect the views of USAID.

ACRONYMS AND ABBREVIATIONS

ACNM	American College of Nurse-Midwives
AIHA	American International Health Association
C–section	Cesarean birth
CDC	Centers for Disease Control and Prevention
CEDPA	Centre for Development and Population Activities
CNM	Certified nurse-midwife
ELD	Electoral district
FCMC	Family-centered maternity care
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
IEC	Information, education, and communication
IMR	Infant mortality rate
IUD	Intrauterine device
JHU/CCP	Johns Hopkins University/Center for Communication Programs
JSI	John Snow, Inc.
KAP	Knowledge, attitudes, and practice
LAM	Lactational amenorrhea method
MAQ	Maximizing access to quality health care
MCH	Maternal and child health
MMR	Maternal mortality rate
NCHS	National Center for Health Statistics
NGO	Nongovernmental organization
PIH	Pregnancy-induced hypertension
PSI	Population Services International
RCT	Randomized controlled trial
RDS	Respiratory distress syndrome
RFPA	Russian Family Planning Association
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TASC/IQC	Technical Assistance Service Contract/Indefinite Quantity Contract
TFR	Total fertility rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
URC/CHS	University Research Corporation/Center for Human Services
USAID	United States Agency for International Development
VCIOM	All Russia Centre for Public Opinion and Market Research
WHO	World Health Organization
WIN	Women and Infant Health Project
WRHP	Women's Reproductive Health Project

EXECUTIVE SUMMARY

INTRODUCTION

The Women and Infant Health (WIN) project, funded by the United States Agency for International Development (USAID)/Russia for implementation between June 1999 and June 2002, aims to improve the effectiveness of maternal and infant health services. Working in close collaboration with Russia's Ministry of Health, the project was designed to improve the quality of care provided by obstetricians/gynecologists, pediatricians, midwives, and nurses. The project has focused largely on training to improve the care provided to women during pregnancy, labor, delivery, and the postpartum period; support for breastfeeding; and family planning counseling provided to women after births and abortions. The project is being implemented in the cities of Perm and Berezniki in Perm oblast and Novgorod City in Veliky Novgorod oblast.

Under the USAID/Washington Technical Assistance Service Contract/Indefinite Quantity Contract (TASC/IQC) mechanism, John Snow, Inc. (JSI) was awarded a three-year contract in June 1999 to implement the WIN project. The project may now be extended for a fourth year, from June 2002 to June 2003. Partner organizations collaborating with JSI in implementing the WIN project are Johns Hopkins University's Center for Communication Programs (JHU/CCP), EngenderHealth (formerly AVSC International), and the University Research Corporation's Center for Human Services (URC/CHS).

The long-term goals of the WIN project are to reduce maternal and infant mortality and morbidity in the project's three sites. These goals are to be achieved by providing training and technical assistance to improve the effectiveness of selected maternal and infant health services, with special emphasis on reducing unwanted pregnancies and abortions. Inputs to improve family planning are provided within the broader context of maternal and infant health, with important project components focusing on maternity care; postabortion care; promotion of breastfeeding and preventive health care of infants; and prevention of sexually transmitted infections (STIs). Major themes of the project include

- training in evidence-based medicine,
- application of and training in quality assurance methods,
- client-centered approaches to reproductive health services,
- improving communications between health care providers and clients, and
- promoting preventive health practices.

It is anticipated that the goals of the project will be achieved by successfully meeting the following objectives:

- provide family-centered maternity care that encourages exclusive breastfeeding and rooming-in,
- provide high-quality prenatal and postnatal care,
- increase training on neonatal resuscitation,
- improve family planning counseling and services during the postabortion and postpartum period,

- increase counseling for STIs, and

- train health care workers to recognize and counsel women who are victims of violence and provide adequate referrals.

SETTING FOR THE WIN PROJECT

Owing mainly to Russia's low fertility rate, the Russian population is declining at a rate of about 6 percent per year. It has been estimated that the current population (145.5 million as of July 2000) will decline to about 125 million by 2025 and 104 million by 2050 (United Nations, 2001:29). The total fertility rate (TFR) as of 2000 was 1.2 children per woman. Only 18.0 percent of the population was below the age of 15 compared with 21.7 percent in the United States (United Nations, 2001:49–50).

Russia's infant mortality rate as of 2000 was 16.7 deaths per 1,000 live births, a figure that is approximately double the level currently prevailing in the United States (United Nations, 2001:41–42). The four leading causes of infant mortality in Russia are complications originating in the perinatal period, congenital abnormalities, pneumonia and influenza, and infectious disease (National Center for Health Statistics [NCHS], 1999:16).

The national government is currently giving priority to preserving and increasing the size of Russia's population. In 1999, direct public sector support for family planning was discontinued by the State Duma (one of the two houses of parliament), and funding was merged into the safe motherhood initiative that now constitutes a major component of the presidential "Children of Russia" program. This action was apparently triggered by political and church worries about Russia's falling population size and concerns surrounding the morality of induced abortion. One of the results of this action is that access to contraception could be more limited for couples that may not be able to afford its cost.

The use of modern contraception does not have a long history or well-developed service delivery infrastructure in Russia. For decades, abortion has been the primary means of family planning in Russia. Currently, each woman averages 2–3 abortions during her lifetime, and some women may have as many as 15 or 20 abortions (Goldberg and Serbanescu, 2001). It should also be noted that the abortion rate has fallen from about 14 abortions per 100 women in 1988 to just under 8 in 1997. This decline has coincided with modest gains in the use of modern contraceptive methods, particularly pills and intrauterine devices (IUDs). The USAID reproductive health strategy currently includes helping Russia convert from reliance on abortion as a primary means to prevent unwanted births to the use of safe and effective methods of contraception.

METHODOLOGY FOR THE ASSESSMENT

The team considered the goals and objectives for USAID's overall WIN strategy and reviewed activities described in WIN project documents in organizing this assessment. In addition to evaluating the performance and accomplishments of the project to date, the following expected results for the project were used to guide the assessment of project impacts:

- a reduction in overall abortion rates with significant reduction in repeat abortions,
- an increase in contraceptive use among sexually active women,
- an increase in the number of women exclusively breastfeeding,
- an increase in the number of hospitals providing rooming-in to mothers,
- an increase in the number of hospitals offering family-centered maternity care as a birthing option,
- guidelines, protocols, and standards defining new approaches to women's and infant health services and practices developed, and
- a decrease in perinatal mortality in project sites.

THE PROMOTION OF FAMILY-CENTERED MATERNITY CARE IN THE WIN PROJECT

One of the key elements of the WIN project is the introduction and strengthening of family-centered maternity care (FCMC) practices in Russia. FCMC is evidence-based medicine applied to the care of pregnant women and their newborns:

- **Mother-Friendly Care**
  - Is designed to meet the informational, social, emotional, comfort, and support needs of pregnant women and their families during pregnancy and childbirth;
  - Emphasizes education and preparation to enable the pregnant woman to take a knowledgeable, active role in promoting her own health and that of her fetus and baby;
  - Encourages involvement of the pregnant woman's family members or other persons of her choice in preparation for childbirth and motherhood and invites their supportive presence during labor and birth;
  - Avoids unnecessary use of invasive, uncomfortable and/or restrictive procedures;
  - Encourages women to be active during labor—to sit up, walk, assume any comfortable position, change positions frequently, and avoid the supine and lithotomy positions; and
  - Manages birth as a process requiring cleanliness but not sterility.

- **Baby-Friendly Hospital Practices**

  - Designed to promote breastfeeding, maternal-infant bonding, lactational amenorrhea, and to reduce newborn infections;

  - Provided to the mother and baby after the baby is born;

  - Promoted worldwide by WHO;

  - Key elements include
    - skin-to-skin contact between mother and baby,
    - rooming-in,
    - exclusive breastfeeding for first 6 months of life,
    - breastfeeding on demand,
    - no bottles,
    - no pacifiers, and
    - expert assistance to prevent and solve breastfeeding problems.

PRINCIPAL FINDINGS AND CONCLUSIONS

JSI is performing well in its role as the WIN project coordinator. Each partnering organization brings comparative expertise to the project that complements the overall project effort. Having these four organizations working together as a consortium appears to be working effectively. This success can be attributed to the highly capable leadership of the JSI resident project director; good working relations between project staff, consultants, and host country counterparts; the effective management of the project by the Health Division of USAID/Russia; and the relatively small size of the consortium.

The WIN project is financed at approximately US $4.0 million over three years. Considering the project design, the scope, and the results expected, the project has a very limited budget. Given the standards of donor-funded projects in other countries, the expectations for the project should be more narrowly defined and commensurate with the available funding and implementation time period for the project.

Russian health providers and mothers that were interviewed during this assessment greatly appreciate and are genuinely enthusiastic about the WIN project. Not only is this small project meeting many of its objectives, but it is also generating enormous good will for USAID and the American people. Russian doctors and midwives are overwhelmingly positive about what they have learned and the resulting changes in how they take care of women. Women and their family members are happy about their birth experiences and grateful for the care they receive, which is very different from what is usually available. Doctors in charge of the services report that the WIN innovations have transformed how doctors and midwives relate to their patients, and that the changes “have been like a breath of fresh air, both for providers and for women.”

In addition, service providers in all three cities reported financial benefits due to less use of medicines and supplies for procedures that are now used less frequently, such as sterile

suture materials, analgesic and anesthetic drugs, baby formula, antibiotics, and intravenous solutions. This money is now available for other uses.

Service providers are also learning the benefits of avoiding the unnecessary use of invasive procedures. They are also impressed and increasingly interested in the importance of basing care on evidence of efficacy. This project may be providing effective lessons in health care reform at the implementation rather than the policy level, without labeling it as such.

The one expectation currently advanced for the project that may be difficult to attain is a major reduction in first time and repeat abortions. Expecting to achieve a rapid rise in family planning use sufficient to significantly reduce abortions over the three-year implementation period of the WIN project may have been unrealistic.

MEASURES OF WIN PROJECT PERFORMANCE

For the purposes of this assessment, reliance was placed on the project's monitoring and evaluation system that compiles quarterly clinic-based information from administrative offices and health facilities affiliated with the WIN project. Service statistics compiled by the WIN project clearly indicate that many of the project's essential FCMC components are being effectively implemented. This is particularly true in the case of exclusive breastfeeding. Other FCMC elements being promoted by the WIN project also appear to be taking hold in health facilities. Nearly all mothers are now rooming-in with their babies, rather than relying on nurseries for life support. This is a remarkable departure from the practices of the recent past. The percentage of mothers with family support during labor and delivery, while still below 50 percent in all participating maternity hospitals, is steadily rising in most instances.

Reliance on pain medications appears to be declining in many WIN project sites. The incidence of episiotomies for vaginal deliveries has also declined. However, cesarean-section levels (which are lower than in the United States) do not appear to have declined substantially in any WIN project site.

Given the increased use of exclusive breastfeeding and the introduction of other FCMC practices in affiliated WIN project health facilities, is there evidence of improved infant health and survival? The WIN project's monitoring and evaluation system tracks numerous indicators of infant morbidity as well as levels of perinatal, neonatal, and infant mortality. Many of these measures clearly show that the WIN project is making a substantial contribution in a very short time. For example, the percentage of infants admitted to intensive care in maternity hospitals has fallen in most project sites. Upper respiratory tract infections and pneumonia have declined in many children's polyclinics. The percentage of infants with jaundice has fallen substantially in some project sites. Another encouraging trend is that the incidence of ear infections (otitis) is about 50 percent lower in health facilities previously reporting high infection rates.

Unfortunately, the number of new family planning acceptors and users does not appear to have risen over the short 15–month reporting period of the project. In fact, in one family planning center, levels of acceptance and use actually declined. The main methods being accepted in family planning centers are pills and condoms, with IUDs, injectable contraceptives, and emergency contraception (morning after pills) being less frequently

employed. Continued use of contraception in the project's study areas is a critically important indicator of project performance. These findings clearly point to the need to strengthen the provision of family planning counseling and services during the last year of the WIN project.

Reports from the gynecological units of maternity hospitals affiliated with the WIN project indicate that there have been some modest reductions in the number of abortions performed in some facilities, but little in the way of decline elsewhere. However, the WIN project does appear to be achieving some success in increasing the percentage of women who accept a family planning method after having an abortion. For example, in the gynecological unit of the Perm–21 maternity hospital, the percentage of abortion clients accepting family planning rose from just 8 percent in the period from July to September 2000 to 57 percent between July and September 2001. This impressive rise, which has not been matched in other areas, may partly be due to the provision of free contraception as part of an operations research study investigating the crucial role family planning can have in reducing abortion levels.

RECOMMENDATIONS

The WIN project should be funded for an additional year to take advantage of and consolidate the success of the project as implemented in the three current sites. A five-year follow-on project should be designed to further enrich the WIN model and to expand the reach of its innovations into every region of the country. In addition, an intensified effort to combat human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) should be a centerpiece of USAID's future health programming in Russia. To this end, the introduction of an affordable high-quality branded condom through an expanded social marketing effort should be a priority over the coming years. A U.S.–Russia commission on reproductive health should be established to better understand and support efforts in this area.

The strategy for extending the reach of WIN project interventions, both in a fourth-year extension and in a follow-on project, should rely heavily on full utilization of extant Russian systems to disseminate new knowledge, practices, and standards throughout the medical/health care system.

The goal should be to provide the additional inputs needed to make the important, successful innovations that have already been introduced strong enough to continue, thrive, and be replicated and institutionalized through processes that are part of the indigenous Russian system. If USAID does not continue to work in this area, then these innovations would continue on the strength of their inherent effectiveness and attractiveness to Russian maternal and child health professionals.

A new five-year project should start in June 2003 and end in May 2008 to permit nondisruptive transition to a new project and to allow sufficient time for implementation. The WIN model should be expanded to one oblast in each of the seven federal regions. This would require replication in five new oblasts, in addition to continuation of the project in Perm and Veliky Novgorod oblasts.

Finally, it is imperative to note that the team is very concerned about the current rise of HIV/AIDS infection in Russia as the epidemic begins to move beyond intravenous drug

users. Russia's health system is not giving adequate attention to HIV prevention. The WIN project provides training to obstetricians/gynecologists and midwives, two categories of health workers that have critical roles in managing sexually transmitted diseases (STDs). Significantly greater resources will need to be directed toward the prevention and treatment of STDs (most critically HIV/AIDS) in the future.

Therefore, in addition to the expansion of a WIN follow-on project, USAID should devote a significant amount of its health assistance efforts in Russia to providing subsidized contraceptives, especially condoms, in order to reduce the spread of HIV infection (which is expanding rapidly beyond injectable drug users) and to reduce the need for abortions. USAID should finance condoms on a massive scale, as well as the development and implementation of a social marketing of condoms program to promote a quality-branded condom at an affordable price, supported by a nationwide campaign targeting the 15–24 year age group.